Portraits from Memory

17—Sir Walter Russell Brain, FRS, PRCP (later Lord Brain)

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In 1964 the new College of Pathologists, founded in 1962, was at last invited to submit recommendations to the Distinction Awards Committee, whose chairman was Sir Russell Brain, later Lord Brain.

Bust of Lord Brain by Epstein.

The president of the college, Sir Roy Cameron, instructed me to undertake "appropriate consultations" among the office bearers of the college and to seek an interview with Russell Brain.

The object of the interview was not to press individual cases but to establish, if possible, the case for more generous treatment of pathologists. This was a reasonable assignment but, from all that I could gather, an interview with Russell Brain would not easily be arranged and would, in any case, be a pretty daunting prospect. I took advice from one who knew him well. I was warned that any appointment made was quite likely to be cancelled, not once or twice but perhaps three or four times. I was also advised to rely on nothing except ascertainable facts and to present these unemotionally. It would be well if I had their essentials on paper to leave behind as a record of our discussion. It was a good thing that I was so wisely advised. Three dates for the interview were duly made and cancelled; but a fourth was kept. When arranging the fourth date I had taken the precaution of telling Russell Brain's secretary that I was not proposing to press individual cases but to establish some general points of policy and practice. I now think that it might have been wise to make this clear from the start.

In any case the fourth date for the interview arrived. It was on a dismal December afternoon when darkness fell quickly and we were suffering power cuts. I arrived in darkness, happily with a pocket torch available, because candles were scarce in Russell Brain's Harley Street office. He greeted me formally but not coldly and apologised for the lack of light. I think that I secured a good mark for being able to produce my pocket torch.

"Where have you come from?" he asked.

"Harley Street," I replied. He expressed surprise.

"I thought you came from Scotland."

"That was a year ago," I answered. "Today I came from the Public Health Laboratory Service headquarters office in Park Crescent. Our back door leads on to Harley Street." He was amused, and the atmosphere seemed more favourable.

Point by point

"Now, what do you want to discuss?" he asked.

"I came to press the general case in favour of more and better awards for pathologists," I answered; and I laid four pieces of paper in front of me on the table. I noticed that he had three pieces of paper in front of himself.

"Go ahead," he said. "What is on your first piece of paper?" I answered, "The published list of awards to consultants in different specialties."

"I have that list in front of me," he said, and went on, "you are not bottom of the list."

"No," I agreed, "did you think we should be?"

"No; perhaps you *are* rather too low," he answered. "What is your second paper?"

"The distribution of awards to consultants in different parts of England and Wales," I answered.

"Well, yes," he said, "I have that list too. Perhaps London does better than it should. We are looking seriously into that. What is your third piece of paper?"

"This," I replied, "is a list of the proportion of awards of different grades made to consultants in different specialties. Pathologists do not seem to be often regarded as fit for category A if they are outside London teaching hospitals."

"No," he agreed, "that is correct. And that is something we shall be looking into seriously. Do not some pathologists have a pretty good second income from coroners' postmortem examinations? And do not some of them spend a good deal of time pursuing that activity?"

He had touched on a point where some pathologists could perhaps be regarded as vulnerable, and I conceded that I understood it but said that I thought that it was not a general problem; and that the growth of scientific investigative work being fostered by the new college would in due course have a favourable effect on the scientific and clinical contributions of pathologists in general. We discussed the terms "merit" and "distinction" as applied to awards.

"Merit," he said, "is a term often applied to the activities of consultants who look after doctors' own families or run the local medical society. I agree that the merits of consultants in pathology are less likely to be obvious. Certainly they do not receive generous gifts or praise from grateful patients!" We touched on the secrecy surrounding the names of holders of awards; and I said that I thought our college would favour publishing the names of those with awards. He explained, however, that the objectors to publishing the names of award holders were not those who had the awards but those who did not have them. The term "Harley Street specialist" might lose significance.

Not without honour

By now the atmosphere was becoming more relaxed, and he permitted himself a smile as he asked: "And what is your fourth piece of paper? I do not have that in front of me."

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"This," I answered, "is the allocation of awards to consultants in Scotland." At his request I passed it over and he scowled at it for some minutes.

"I see," he said, "that pathologists and physicians rank almost side by side in Scotland. How does that come about?"

With what tact and care I could muster I emphasised that departments of pathology were very highly regarded in Scotland and that some who aspired to become consultants in pathology gladly enough turned to clinical medicine or surgery if they found themselves falling behind in the promotion race; and indeed that many budding physicians and surgeons regarded a year or two in pathology as a good way of preparing for their clinical careers. I also explained that the four university departments of pathology in Scotland were by no means ivory towers but accepted in full a service commitment to their teaching hospitals and to nearby peripheral hospitals as well.

"Remarkable," he said; "and I see that your new college has its share of that breed."

"I promise," he said as we parted, "that due weight will be given to your arguments." He was as good as his word. Before he died in December 1966 a visible and upward trend in favour of pathologists was well established.

From our one and only meeting I concluded that he was a much warmer man than was generally realised.

Lesson of the Week

Incidence of unsuspected fractures in traumatic effusions of the elbow joint

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Radiological signs of an effusion of the elbow are the presence of the posterior fat pad and elevation of the anterior fat pad in a lateral radiograph. It has been suggested that when an elbow effusion is present after trauma a fracture is also likely to be present.[1-3] The aim of this study was to determine the incidence of fractures not seen in the radiograph at presentation when a traumatic elbow effusion was present radiologically.

All patients with traumatic effusion of the elbow in whom radiography at presentation does not show a fracture should undergo repeat radiography seven to 14 days later

Patients, methods, and results

All patients who had anteroposterior and lateral radiographs taken of the elbow after trauma and in whom the radiographs showed effusion but no clear fracture returned for repeat anteroposterior and lateral radiography of the elbow seven to 14 days after the initial trauma. The study comprised 35 patients (19 male and 16 female). The age range was 9-73 years, nine patients being under 16.

At presentation 31 radiographs showed elevation of both fat pads and four showed elevation of only the anterior fat pad. In 10 cases there was evidence of a fracture in the radiograph taken seven to 14 days later. In these 10 cases all the fractures were of the intra-articular aspect of the radius (seven the radial neck and three the radial head). Nine of the 10 fractures were in patients with elevation of the anterior and posterior fat pads in the initial radiograph; in the other case only the anterior fat pad was elevated in the presenting radiograph. Two fractures were in patients aged under 16.

The fracture was visible in the radiographs at follow up because of bone resorption at the site of the fracture (nine cases) or a periosteal reaction at the radial neck (one case).

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Discussion

Under normal circumstances the posterior fat pad lies within the olecranon fossa and is not visible, whereas the anterior fat pad occupies the shallower anterior coronoid and radial fossae and may be visible[1,2] (fig 1). Anatomically the fat is intracapsular but extrasynovial.[3] With an intra-articular effusion the fat pads are displaced out of their fossae, so that the posterior fat pad becomes visible and the anterior fat pad elevated (fig 2).

At immediate supplementary radiographic examination Norell found 10 fractures not visible on routine examination of the elbow in 12 children with traumatic elbow effusion (the sites of the fractures were not mentioned).[1] In another study of children with traumatic elbow effusion eight cases of small fracture were missed in the original radiographs. Of the remaining 12 children, who had follow up radiography at eight days to one month, five showed a periosteal reaction around the distal humerus, one due to osteitis and the four others to trauma.[4]

This study showed an incidence of fracture of 29% (10/35) in patients in whom an effusion but no fracture was visible on initial radiography. Though specific supplementary views taken at presentation—of the radial head or the radial head-capitellum,[5] for example—might have shown several of these fractures at presentation, in practice the patient has usually left the radiography department before a radiologist could request these specific views.

Traumatic elbow effusion should be treated initially with a broad arm sling and analgesics. If a subsequent radiograph at seven to 14